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	09G098	A. BUILDING _____ B. WING _____	10/02/2008

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W 000	INITIAL COMMENTS A recertification survey was conducted from September 30, 2008, through October 2, 2008, utilizing the fundamental survey process. A random sample of three clients was selected from a residential population of five females with mental retardation and varying disabilities. The survey findings were based on observations in the group home and at three day programs, interviews, and a review of records, including unusual incident reports.	W 000	Received 10/23/08 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interviews, and the review of records, the facility's governing body failed to provide general operating directions over the facility as evidenced by the following: The findings include: 1. The Governing Body failed to ensure that persons with no ownership or controlling interest in the facility consistently participated on the Human Rights Committee (HRC). [See W261] 2. The Governing Body failed to ensure that the HRC reviewed, approved and/or monitored the use of door alarms. [See W264]	W 104	The governing body of MTS will insure that persons with no ownership or controlling interest in the facility participate in the Human Rights Committee forums. MTS has identified community and other outside representatives but they did not attend the meeting reviewed by the surveyor. Going forward MTS will insure that these individuals attend by insuring that they have timely notification, that confirmation calls are made no more than 48 hours before the meeting date and by insuring that meeting times are optimal for the outside parties...10-30-08.	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client,	W 124	The governing body will insure that the Human Rights Committee reviews the door alarm issue in its next meeting for the individuals supported at 55th Street. 10-30-08.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Freda A-Edwards for Evette Moore
TITLE: Director of Residential Service
(X6) DATE: 10/23/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the rights of each client and/or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment, for two of three clients included in the sample. (Client #1 and #2) The findings include: 1. Review of Client #1's medical record on October 1, 2008 at 3:34 PM revealed the following written physician's orders: a. On September 16, 2008, Client #1 was administered Ativan 2 mg by mouth one hour prior to her Audiological appointment. Interview with the facility's Nursing Coordinator (NC) confirmed that the sedation was given on September 16, 2008. b. On August 4, 2008, Client #1 was administered Ativan 2 mg by mouth one hour prior to her ENT appointment. Interview with the facility's NC confirmed that the sedation was given on August 4, 2008. c. On June 26, 2008, Client #1 was administered Ativan 2 mg by mouth one hour prior to an ultrasound appointment. Interview with the facility's NC confirmed that the sedation was	W 124		

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W 124	Continued From page 2 given on June 26, 2008. d. On December 18, 2007, Client #1 was administered Ativan 1 mg by mouth x 3 doses prior to her MRI and Echo appointments. Interview with the facility's NC confirmed that the sedation was given on December 18, 2007. Interview with the Qualified Mental Retardation Professional (QMRP) and review of Client #1's Psychological Assessment dated April 1, 2008 on October 2, 2008 at approximately 3:40 PM revealed Client #1 was not able to make independent decisions and/or give consent for the use of medications and habilitation services. The QMRP revealed the Client #1 had a legal guardian to assist her in decision making. Further interview with the QMRP revealed informed consent had not been obtained from the client's legal guardian for the aforementioned sedations. 2. Observation of the evening medication administration on September 30, 2008 at 6:50 PM revealed Client #1 received Risperdal 1 mg by mouth. Interview with the Nursing Coordinator during the medication administration, revealed that the medication was used to address the client's maladaptive behaviors. Review of the client's current physicians orders on September 2008 revealed that the psychotropic medications were incorporated in a Behavior Support Plan (BSP) dated January 2, 2008, that addressed behaviors associated with stereotyped (persistent hand flapping, waving with loud vocalizations at any time particularly before meals or when attempting to avoid a person or task).	W 124		

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W 124	Continued From page 3 Interview with the facility's Qualified Mental Retardation Professional (QMRP) on September 30, 2008 at approximately 8:45 AM revealed that Client #2 was not able to provide consent for treatment and did not have a court appointment guardian and/or involved family members. Review of Client #2's Psychological Assessment dated January 2, 2008 on October 1, 2008 at approximately 1:47 PM revealed that the client was not able to make independent decisions concerning her residential or day program placement, treatment plan, or financial affairs. There was no documented evidence that the facility informed Client #2 or a legally-authorized representative of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124	W124 The QMRP and RN did inform he legal guardian of the need to sedate client #1 to routinely complete medical appointments successfully. The guardian agreed, however, signed consent was not obtained and the guardian was not informed case-by-case. The QMRP and RN will follow up with the guardian to insure that consent is obtained prior to each appointment...10-30-08. In addition, the Executive Director has modified the QMRP monthly reporting form so that QMRPs are now required to report on the status of any/all consent issues...10-30-0	
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain client's rights and/or ensure each client was encouraged to exercise their rights, for three of five clients residing in the facility. (Clients #1, #3, and #4)	W 125		

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W 125	Continued From page 4 The finding includes: During the environmental walk thru on October 2, 2008 at approximately 12:30 PM, Clients#1, #3, and #4 were observed to have door alarms on the exit/entrance doors located inside their bedrooms. Interview with the House Manager (HM) revealed that the alarms were placed on the doors to address Client #1's target behavior of running away. Further interview with the HM revealed that she was not sure why an additional door alarm was placed on Client # 3's door. It should be noted that Clients #1 and #4 are roommates. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2008 at approximately 12:50 PM revealed that the facility's Human Rights Committee (HRC) was unaware of the door alarms that were placed on the doors of Clients #1, #3, and #4. Review of the HRC minutes on October 1, 2008 at approximately 3:01 PM confirmed the QMRP's statement. Continued interview with the QMRP revealed that the clients were not informed about the use of the door alarms. The QMRP further revealed that the client's legal guardians and/or involved family members had not been made aware of the purpose of the door alarms and/or agreed to their use. Review of the Client #1, #3, and 4's psychology assessments indicated that they did not evidence the capacity to make independent decisions on their own behalf regarding habilitation planning, placement, treatment, financial or medical matters.	W 125	W125 MTS will insure that the door alarms issue is discussed by the Human Rights Committee in its next meeting and that the committee's recommendations are documented and addressed by the interdisciplinary team...10-30-08	

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W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on interview and the record review, the facility failed to provide evidence that assured a system had been established that maintained a complete accounting of each clients' personal funds, for one of the three clients (Client #3) included in the sample. The finding includes: The facility failed to ensure that Client #3 was reimbursed for the eye glasses purchased with her money as evidence below: Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2008, at approximately 10:30 AM revealed that Client #3 was not capable of managing her finances. Further interview with the QMRP revealed the facility was responsible for managing the client's finances in collaboration with the Department of Disability Services (DDS). Review of Client #1's financial records revealed $279.00 was debited from the account on August 1, 2008 to purchase eye glasses. Continued interview with the QMRP confirmed that the eye glasses were purchased with Client #1's money. The QMRP stated that there was an agreement that the facility would purchase Client #1's eye glasses and DDS would pay for the	W 140	W140 Client #3 came to MTS without money. She needed both eyeglasses and to enjoy the vacation planned for her housemates. As mentioned by the surveyor, DDS did indeed agree to fund the vacation and did but the agreement on the eyeglasses was slightly different than was stated. MTS agreed to pay up front for client #3's glasses but with the understanding that client #3 would pay back when she was financially able. It should be noted that client #3's glasses were not paid for by her Medicaid benefits because of the high cost of her needed prescription. The IFP was not modified to reflect these team	

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W 140	Continued From page 6 vacation.	W 140	decisions so MTS will restore the $279.00 dollars to client #3's account 10-30-08.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's active treatment program was integrated, coordinated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure the facility to ensure each client was encouraged to exercise their rights. [See W125] 2. The QMRP failed to establish and maintain a system that ensured a complete and accurate accounting of client funds. [See W140] 3. The QMRP failed to ensure staff were capable of effectively implementing the client's feeding protocol. [See W194] 4. The QMRP failed to ensure staff held evacuation drills at least quarterly for each shift of personnel and during varied conditions. [See W440 and W441]	W 159	W159 The issues cited under W159 have been addressed as evidenced by the included responses for W125, W140, W194 and W440.	
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are	W 194		

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W 194	Continued From page 7 responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure staff were capable of effectively implementing a client's feeding protocol for one of three clients included in the sample. (Client #1) The finding includes: The facility failed to ensure direct care staff implemented Client #1's Mealtime Protocol as evidence below: On September 30, 2008 at 5:55 PM, Client #1 was served chicken, scallop potatoes, side salad, and dinner rolls for her dinner. At 6:00 PM, Client #1 was observed to eat and drink at a rapid pace with no staff intervention to slow down. At 6:10 PM, Client #1 was given more vegetables and peaches and received verbal prompts to slow her eating pace. Interview with the direct care staff revealed that Client #1 eats very fast and was at risk for aspiration. Further interview with the direct care staff revealed that she had received training on Client #1's Mealtime Protocol. Interview with the Qualified Mental Retardation Professional (QMRP) on October 2, 2008 at approximately 10:50 AM revealed that all staff had received training on Client #1's Mealtime Protocol. Review of the inservice training records on October 2, 2008, at approximately 11:30 AM verified that all staff had received training on "Feeding Protocols" on July 17, 2008.	W 194		

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W 194	Continued From page 8 Review of Client #1's medical records on October 1, 2008 at 3:04 PM revealed a Mealtime Protocol dated March 2008. According to the protocol, staff were to implement the following technique/instructions: - monitor pacing of meal intake; provide verbal prompts to slow down, put utensils down and chew; - provide verbal cures to "use her napkin" - this should occur after every 3 bites of food (may help to decrease pace) - closely monitor for any signs/symptoms of aspiration. At the time of the survey, the facility failed to provide evidence that staff were effectively trained on how to implement Client #1's mealtime protocol.	W 194	W194 The QMRP will insure that staff is retrained on the feeding protocol for client #1 by...10-30-08. In addition, the QMRP will observe at minimum two meals weekly and the facility manager 3 meals weekly to insure that staff consistently implements the feeding protocol as prescribed...10-30-08.	
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in	W 242		

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W 242	Continued From page 9 privacy, for one of three clients included in the sample. (Client #3) The finding includes: The facility failed to ensure Client #3 received training to address privacy when using the bathroom. On September 30, 2008 at 5:18 PM, Client #3 was observed with her lower body exposed while seated on the toilet. The bathroom door was wide open. Interview with the direct care staff on the same day at approximately 5:25 PM revealed that Client #3 had to be verbally almost daily to closed the door when she uses the bathroom. Further interview did not reveal any evidence that the client was receiving training in privacy while using the bathroom. Review of Client #1's IPP dated September 5, 2008 on October 1, 2008 at 12:31 PM failed to provide evidence of a training objective to assist the client with maintaining her privacy while using the bathroom. At the time of the survey, the facility failed to ensure Client #1 received privacy training.	W 242	W242 The QMRP will insure that staff is retrained on the privacy issue giving particular attention to the issue of insuring privacy while toileting...10-30-08. It should be noted that staff routinely monitor bathroom use with client #3 to insure that she respects her own privacy but did not do so on the date of the observation as noted by the surveyor. A protocol will be developed (as opposed to a formal program) supporting client #3 in respecting her own privacy and staff will be trained on the implementation of this protocol by...10-30-08.	
W 261	483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.	W 261		

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W 261	Continued From page 10 This STANDARD is not met as evidenced by: Based on interview and review of the Human Rights Committee (HRC) minutes, the facility failed to ensure that persons with no ownership or controlling interest in the facility consistently participated on this committee. The finding includes: Review of the Human Rights Committee (HRC) meeting minutes was conducted on October 1, 2008 at approximately 2:20 PM. According to the HRC minutes dated September 26, 2008, Client #1 and Client #2's Behavior Support Plans (BSP) and psychotropic medications were discussed and approved. Further review of the corresponding signature sheet attached to the minutes failed to evidence that the facility's HRC committee included persons with no ownership or controlling interest. Interview with the Qualified Mental Retardation Professional (QMRP) on October 1, 2008 at approximately 4:00 PM acknowledged the lack of a community representative present during the meeting.	W 261	**W261** **MTS has community, outside representatives on the HRC and will insure that its outside members attend all planned meetings and that their attendance/participation is documented...10-31-08.**	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility's specially-constituted committee (Human Rights Committee) failed to ensure that restrictive programs were used only with written informed	W 263		

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W 263	Continued From page 11 consent, for one of three clients included in the sample.(Client #2) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on September 30, 2008 at approximately 8:47 AM revealed that Client #2 Behavior Support Plan (BSP), that incorporated restrictive measures (psychotropic medications) was being implemented without attaining written informed consent from the client or a legally authorized representative. At the time of the survey, there was no evidence that the HRC ensured written informed consent had been obtained for the use of Client #2's BSP.[See W124]	W 263	W263 The QMRP is pursuing a legal guardian for client #2 as supported by the DDS support coordinator. MTS will insure that a legal guardian is obtained for client #2 and that this individual is subsequently involved in all major decisions for client #2 that have rights implications. MTS will also seek the support of the Quality Trust in obtaining the needed legal guardian. The QMRP will review progress on follow up in her monthly notes...10-30-08.	
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility Human Rights Committee failed to reviewed, approved and/or monitor the use of door alarms for three of five clients residing in the facility. (Clients #1, #3, and #4). The finding includes:	W 264		

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W 264	Continued From page 12 Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's HRC meeting minutes on October 1, 2008 failed to provide evidence that the HRC met, monitored and discussed the facility's practices regarding the use of door alarms. [See W125]	W 264	W264 The HRC will review the door alarm issue on 10-31-08.	
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on staff interview and the review of fire drill reports, the facility failed to hold evacuation drills at least quarterly for each shift of personnel. The finding includes: Interview with the House Manager (HM) on September 30, 2008 at 2:51 PM revealed the facility had five shifts of direct care personnel. The shifts were weekdays 6 AM - 2 PM, 2 PM - 10:00 PM, 10:00 PM - 6 AM and on weekends 6 AM - 6 PM and 6 PM - 6 AM. Review of the fire drill reports from February 2008 to August 2008 revealed that no fire drills were conducted for the 6 AM-2 PM morning weekday shift. Additional review of the records revealed that there were no fire drills conducted from September 2007 to January 2008 during the overnight shifts during the week. Further interview the HM acknowledged that fire drills were not conducted quarterly on each shift. At the time of the survey, the facility failed to provide evidence of fire drills conducted quarterly as required.	W 440	W440 MTS will insure that a fire drill is held for each shift (5 TOTAL) in both November of 2008 and December of 2008. A 2009 schedule will be developed that reflects planned fire drills for each shift quarterly. The 2009 plans will be developed by 11-30-08. Additionally, staff training will be completed so that staff understands that in a fire situation or a drill, the nearest exit is used by each person in the home. Staff will be trained as well to document the exits used and for whom 10-30-08.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G098	A. BUILDING _____ B. WING _____	10/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	927 55TH STREET, NE WASHINGTON, DC 20019

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W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on the interview and review of the fire drill records, the facility failed to conduct fire drills under varied conditions. The findings includes: Review of the facility's fire drill records on September 30, 2008 at 2:51 revealed that most of the fire drills were conducted via the front and back door exits. Interview with the House Manager (HM) on the same day at approximately 3:00 PM revealed that the facility had at least five method of egress. Further review of the fire drill record revealed that the two exits in Client #1 and #3's bedroom and the basement exit had not been used at least quarterly on each shift. There was no evidence that evacuation drills were held under varied conditions.	W 441	W441 See responses for W440 above.	
W 455	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the implementation of infection control procedures to prevent communicable infectious diseases for one of three clients included in the sample. (Clients #1)	W 455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G098	A. BUILDING _____ B. WING _____	10/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	927 55TH STREET, NE WASHINGTON, DC 20019

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W 455	Continued From page 14 The finding includes: On September 30, 2008 at 6:07 PM, Client #1 was observed to stick her index/middle fingers from both hand inside her mouth, rub the bottom of her shoes, and place the same fingers back inside her mouth during her dinner meal. The direct care staff monitoring Client #1 as she ate did not encourage or redirect the client to go to the bathroom to wash her hands. Interview with the direct care staff on the same day at approximately 6:55 PM revealed that she had received training on infection control. Review of the staff in service training book on October 2, 2008 at approximately 11:30 AM revealed that all staff had received training infection control. There was no evidence that the training to prevent infectious diseases was effective.	W 455	W445 Staff will be retrained on infection control issues with focus given to hand washing...10-30-08. The QMRP and Facility Manager will observe active treatment separately on a weekly basis (QMRP – minimum twice weekly, Facility Manager – minimum 3 times weekly) to insure that effective infection control practices are routinely exhibited and to insure that active treatment is routinely implemented by staff on duty...10-30-08.	

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD03-0236	A. BUILDING _____ B. WING _____	10/02/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
M T S	927 55TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS A licensure survey was conducted from September 30, 2008, through October 2, 2008, utilizing the fundamental survey process. A random sample of three clients was selected from a residential population of five females with mental retardation and varying disabilities. The survey findings were based on observations in the group home and at three day programs, interviews, and a review of records, including unusual incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the interview and review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check. The finding includes: Interview with the House Manager and review of the personnel files on October 2, 2008 at 10:59 AM revealed the GHMRP failed to provide evidence of a criminal background checks that disclosed a seven year listing of all jurisdictions where four (4) staff persons had worked or resided at the time of the survey	R 125		

Freddie A-Edwards emcp for Evette Moore TITLE Director of Residential Services DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE